STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155135	A. BUILDING 01 B. WING	02/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN 47421

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/06/13 Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Westview Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility determined to be of Type V (111) construction with a basement was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Fifteen	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident rooms on Cottage hall were provided with hard wired smoke detectors and the other 46 resident rooms had battery powered smoke detectors. The facility has a capacity of 95 and had a census of 65 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for one garage used for facility storage which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/08/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 5 corridor doors on Service hall would latch into its frame. This deficient practice could affect 6 residents in the adjacent dining room as well as visitors and staff. Findings include: Based on observation on 02/06/13 at 2:20 p.m. with the Maintenance Supervisor, the two doors leading into the unisex bathrooms on service hall which is adjacent to the Dining and Activity room on Visions hall would not latch into their frames. Based on interview on 02/06/13 at 2:24 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned corridor doors did not	K0018	**K018** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Latching devices were installed on the two staff bathroom doors located in the service hallway on 2/13/2013 allowing them to latch into their frames. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Other doors throughout the building were examined and none were found to be in need of latching	02/13/2013

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	have any latching devices, they simply swung open and shut and would not latch into their frame. 3.1-19(b)		devices. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Regular Maintenance rounds will continue to ensure that all latching devices operate properly. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance rounds documentation will be reviewed by the QA & A Committee to ensure compliance.	

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observations and interview, the facility failed to ensure 1 of 31 portable ABC class fire extinguisher pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 6 residents in the adjacent dining and activity room on Visions hall as well as visitors and staff. Findings include: Based on observation on 02/06/13 at 3:00 p.m. with the Maintenance Supervisor, the gauge on the ABC Class portable fire extinguisher in the S.C.U. Dayroom adjacent to Visions hall showed the extinguisher to be discharged. Based on interview on 02/06/13 at 3:01 p.m. with the Maintenance Supervisor, it was agreed the gauge reading was not in the normal operating range and it would	K0064	**K064 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**The identified extinguisher was replaced the same day as the visit. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**An outside Fire and Safety vendor performed a complete review of all existing extinguishers throughout the building on 2/12/2013 and found all to be in compliance and in working order. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**Regular Maintenance rounds will continue to ensure that all extinguishers operate properly. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**Maintenance rounds documentation will be reviewed by the QA & A Committee to ensure compliance.	02/13/2013

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	affect the operation of the fire extinguisher. 3.1-19(b)			

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K0147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 power strips was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in room # 36, as well as visitors and staff. Findings include: Based on observation on 02/06/13 at 1:11 p.m. with the Maintenance Supervisor, medical equipment, an oxygen concentrator, used a power strip to draw power from a wall outlet. Based on interview on 02/06/13 at 1:12 p.m. it was acknowledged by the Maintenance Supervisor, a power strip was used for the oxygen concentrator. 3.1-19(b)	K0147	**K147** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The identified power strip was removed on the day of the visit. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All rooms throughout the building were inspected and no other power strips were found with medical equipment drawing power from them. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Regular Maintenance rounds will continue to ensure that all medical equipment is being powered properly. **How the corrective action(s)**	02/13/2013

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			will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance rounds documentation will be reviewed by the QA & A Committee to ensure compliance.	